

**Statement
of the
American Hospital Association
before the
Health Subcommittee
of the
Committee on Ways and Means
of the
U.S. House of Representatives**

“Medicare Payment Advisory Commission Hospital Policy Issues Hearing”

July 22, 2015

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment for the record on recent Medicare Payment Advisory Commission (MedPAC) hospital policy recommendations to Congress. The issues raised in their reports are of great interest to our member hospitals and health systems and the communities they serve.

HOSPITAL SHORT-STAY POLICY ISSUES

In its June report, the commission made several recommendations regarding hospital short inpatient stay issues, including that the Centers for Medicare & Medicaid Services (CMS) withdraw its two-midnight policy. **The AHA appreciates the commission’s willingness to tackle this complicated set of issues and believes that it has the opportunity to make significant policy recommendations in this area. We support some of the recommendations but have concerns that others would not achieve the commission’s articulated goals.**



If the two-midnight policy is withdrawn, hospitals would no longer be required to follow this arbitrary time-based benchmark. Hospitals also would lose the certainty of an inpatient payment for a stay spanning at least two midnights, and be subject to the overzealous audits of the recovery audit contractors (RACs). Currently, the AHA is gathering feedback from our members related to MedPAC's recommendation that CMS withdraw its two-midnight policy.

In addition, CMS recently proposed changes to the two-midnight rule in the calendar year (CY) 2016 hospital outpatient prospective payment system (PPS) proposed rule. We are reviewing this proposal closely; however, our initial perspective is that the proposed changes are a good first step. For example, the nation's hospitals appreciate CMS's proposal to maintain the certainty that patient stays of two midnights or longer are appropriate as inpatient cases. We also agree with CMS's proposal that stays of less than two midnights should be paid on an inpatient basis based on the medical judgment of a physician.

Now that both MedPAC and CMS have reviewed the flawed two-midnight policy and have provided the hospital field with an opportunity to have a constructive dialogue with CMS, it would be premature to take legislative action on any short-stay policy at this point. We do, however, urge Congress to extend the partial enforcement delay of the two-midnight policy beyond Sept. 30, 2015. **In light of the fact that any changes CMS implements through the outpatient PPS rulemaking process will take effect Jan. 1, 2016, we urge Congress to extend the partial enforcement delay of the two-midnight policy until March 30, 2016.** This will not only provide additional time for CMS to issue guidance related to any new policies or admission criteria for hospitals and review contractors, but will allow hospitals time to implement any new policies put forth by the agency.

RECOMMENDATIONS RELATED TO THE MEDICARE RAC PROGRAM

We support MedPAC's recommendation for CMS to base each RAC's contingency fees, in part, on its denial overturn rate. RACs should be held financially accountable for their overzealous audit behavior, and this change could help address the misaligned financial incentives that drive inappropriate RAC denials. It is important, however, that the amount of the performance adjustment be significant in value. It also is important that CMS accurately define and vet with stakeholders the metrics that measure RACs' overturn rates – currently, the agency's methodology is flawed and artificially deflates the overturn rates. For example, it does not account for the fact that appeals of RAC denials are rarely heard in the same year the denial was made.

Further, CMS's forthcoming RAC contracts will likely not account for overturns at all levels of appeal – the agency proposes to include only overturns at the first level of appeal in calculating a RAC's overturn rate. However, these first-level appeals consist of Medicare Administrative Contractor desk audits of the paper record, and are largely considered to be cursory reviews that are biased toward upholding the denial. It is not until the third level of appeal, heard by an administrative law judge (ALJ), that hospitals receive a review of all evidence by an objective party (that is, a reviewer who is not a Medicare contractor). As such, hospitals appealing

inpatient claims to an ALJ have won overturn of the denial 72 percent of the time, according to the Department of Health and Human Services' Office of Inspector General. The final outcome of an appealed claim must be used to calculate fair and accurate overturn rates.

We are concerned that MedPAC's additional RAC-related recommendations, though well-intentioned, would not achieve their stated goal of relieving hospital administrative burden.

First, the recommendation that CMS focus reviews of short inpatient stays on hospitals with the highest rates of short stays would neither reduce RAC scrutiny nor administrative burden for hospitals that are not targets of the short-stay audits, nor decrease the overall number of claims audited and denied by RACs. This is because RACs are not limited to auditing short inpatient stays; they may receive approval from CMS to audit any number of Medicare payment rules. Further, CMS allows RACs to audit a certain number of claims per hospital, based on the hospital's Medicare volume (e.g., for large hospitals, RACs can request 600 records every 45 days). The contingency fee structure encourages RACs to demand the maximum number of records every time period. Unless CMS also reduces the audit limits, RACs simply will shift their focus to other audit issues for those hospitals that do not have high rates of short stays.

Similarly, the recommendation that CMS evaluate a formulaic penalty on "excess" short stays to substitute for RAC reviews of short inpatient stays would not curb RAC review for those hospitals unless corresponding reductions are made to RAC audit limits. These hospitals simply would be subjected to the penalty *in addition to* routine RAC audits. We are deeply concerned about the concept of applying penalties based on an arbitrary threshold of what constitutes an "excess" number of short stays. It is unclear how an "excess" number of short stays would be determined. Setting an arbitrary threshold clouds the role of physician judgment, flies in the face of the Medicare program's longstanding policy that medical necessity drives coverage decisions, and ignores legitimate variation in practice. It is imperative to establish any and all policies in a way that recognizes medical necessity and the critical role of physician judgment.

Finally, the recommendation to shorten the RAC lookback period for review of short-stay inpatient claims would create a more level playing field and likely would allow hospitals to rebill more claims. **However, even if the RAC lookback period is shortened to six months for patient status reviews, as CMS has proposed for its next round of RAC contracts, hospitals would not be able to pursue any appeals rights before the one-year filing limit expires.** They would, therefore, have to continue to forgo their appeals rights in order to rebill claims. This is because a hospital could not receive and reply to an audit request from a RAC, receive a RAC denial, prepare an appeal and receive an appeal decision before the one-year filing limit expires. As is illustrated in the attached appeals timetable, it can take six months from the date a RAC denial is received just to get through the first level of appeal. **Alternatively, as noted below, we urge the committee to eliminate CMS's application of the one-year filing limit to rebilled claims.**

Hospitals carefully evaluate claim denials to determine whether to invest time and resources in filing an appeal; they appeal claims because they stand behind the clinical judgment of the physicians who made the decision to admit the Medicare beneficiary. Hospitals that have provided medically necessary services to Medicare beneficiaries should not face the choice of

conceding to outpatient payment – which is often lower – or being penalized for pursuing their appeals rights by potentially receiving no payment at all.

We continue to urge the committee to consider and support the following additional changes to address the systemic problems with the RAC program:

1. **Prohibit any payment structure that encourages RACs to deny claims.** The current contingency fee structure is one-sided in that RACs can deny claims with impunity. Instead, RACs should be paid similarly to other Medicare contractors, such as through a cost-based contract.
2. **Impose a financial penalty on RACs when a denial is overturned on appeal.** A penalty assessed in such instances would curb overzealous RACs and create a level playing field for both RACs and providers in addressing incorrect payments.
3. **Require RACs to consider only the medical documentation available at the time the admission decision was made in determining whether an inpatient stay was medically necessary.** Currently, RACs can review claims three years after the date of service and are able to utilize information that may not have been available to the physician at the time of the admission decision in order to deny claims. This requirement would restrain RACs' current practice of second-guessing physicians' judgment based on the outcome rather than the facts the physician had at the time.
4. **Eliminate application of the one-year filing limit to rebilled Part B claims.** When a Part A claim for a hospital inpatient admission is re-opened and denied by a Medicare review contractor because the inpatient admission was determined to be not reasonable and necessary, the hospital should be able to submit a subsequent Part B claim for services provided within 180 days of a revised or final determination. This would allow hospitals to either rebill immediately after the claim is denied or pursue their appeals rights and receive a final determination on the Part A claim before rebilling under Part B.
5. **Limit RAC auditing of approved issues to a defined time period, instead of approving them indefinitely, as is now the practice.** After the issue's audit time period has expired, RACs should be prohibited from auditing that issue. CMS should then analyze the audit results and offer education to providers in that jurisdiction if warranted. A RAC would need to seek new approval from CMS to audit for that same issue again, but must wait a certain defined time period to allow providers to incorporate education before requesting new approval. Additionally, a senior CMS official should be held accountable for approval of audit issues.

We also urge the commission to review the proposals set forth by CMS in the CY 2016 outpatient PPS proposed rule related to RAC reviews of patient status claims. While we are waiting for further clarification from CMS on how this process will work, we are pleased CMS proposed to make Quality Improvement Organizations (QIOs) the first line of medical review instead of RACs, in order to prevent RACs from making inappropriate denials of patient status determinations.

SITE-NEUTRAL PAYMENT RECOMMENDATIONS

MedPAC has, on numerous occasions, focused on reducing or eliminating differences in payment rates across care settings because it believes this causes distortions in provider incentives. Specifically, the commission has recommended that the differences in payment rates between hospital outpatient departments (HOPDs) and physician offices for 66 selected ambulatory payment classifications (APCs) be reduced or eliminated. In addition, in 2011, MedPAC adopted a site-neutral payment policy recommendation for 10 evaluation and management (E/M) clinic visit services. The commission also has discussed applying a site-neutral payment policy to a set of 12 surgical service APCs, which would reduce HOPD payment to the level paid in an ambulatory surgical center (ASC).

The AHA opposes these site-neutral payment policy recommendations for the following reasons:

- Hospitals already lose money treating Medicare patients in the HOPD (with negative 12.4 percent margins in 2013). We are concerned that further payment reductions would threaten access to critical hospital-based “safety net” services. HOPDs provide services that are not otherwise available in the community to vulnerable patient populations, such as care for low-income patients, for patients with multiple chronic conditions, the disabled and dual-eligible patients.
- Site-neutral payment reductions would endanger hospital’s ability to continue to provide 24/7 access to emergency care and stand-by capacity for disaster response. Without adequate, explicit funding for these emergency standby services, the stand-by role is built into the cost structure of full-service hospitals and supported by revenue from direct patient care – a situation that does not exist for physician offices or any other type of provider.
- Payment to hospitals for outpatient care should reflect HOPD costs, not physician or ASC payments. HOPD payment rates are based on hospital cost report and claims data. In contrast, the physician fee schedule, in particular the practice expense component, which is relevant for the site-neutral payment methodology, is based on voluntary responses to physician survey data and has been held flat for years due to the cost of various physician payment “fixes.” ASCs do not report their costs.
- The Medicare payment systems for physicians, ASCs and HOPDs are complex and fundamentally different, with many moving parts. Practically speaking, this makes the application of MedPAC’s site-neutral policy unstable, with any number of small technical and methodological decisions changing the outcome significantly. Basing hospital payments on such a volatile methodology could have unintended consequences.

GRADUATE MEDICAL EDUCATION

Changing health care needs have policymakers focused on revisiting the financing of graduate medical education (GME) and how physicians are trained. In a 2010 report, MedPAC asserted

that indirect medical education (IME) payments exceed costs and recommended using the “excess” amount for a performance based payment program that would reward hospitals that meet unspecified educational outcomes and standards. The commission also recommended that the Department of Health and Human Services study a range of issues, including the optimal number of residency slots needed by specialty. MedPAC did not recommend an increase in the number of residency positions.

Unfortunately, the commission’s proposals overlook the rationale for the current GME payment structure and suggest replacing it with new, untested financing models. **The AHA opposes proposals that would alter the GME financing structure in a way that would reduce direct GME or IME payments to teaching hospitals. Reductions in Medicare financing for medical education would threaten the stability and predictability teaching hospitals need to train physicians for evolving health care system needs and would limit the ability of teaching hospitals to offer state-of-the-art clinical and educational experiences.**

The AHA urges MedPAC and other policymakers to ensure that teaching hospitals continue to have the financial support necessary to continue training talented and diverse physicians. To that end, the AHA strongly supports the Resident Physician Shortage Reduction Act of 2015 (H.R.2124/S. 1148) to add 15,000 residency slots by 2021. The legislation outlines a hierarchy for distributing the new slots, prioritizing teaching hospitals in states with new medical schools, currently have more residents than their Medicare-funded slots, and/or train physicians in community or outpatient settings. At least half of the new slots would be for specialty residency programs with shortages, as determined by the Health Research Services Administration (HRSA). **The AHA urges the committee to end the 18-year freeze on the number of physician training positions that Medicare funds and to support the creation of at least 15,000 new residency positions, as included in this legislation.**

340B DRUG PRICING PROGRAM ISSUES

In May 2015, the commission issued its report to Congress on the 340B Drug Pricing Program. The report was requested by members of the House Energy and Commerce Committee. We are pleased that the commission choose not to insert Medicare policy recommendations into a non-Medicare payment policy area. We also compliment the commission’s restraint in not pre-empting HRSA’s plans to issue comprehensive interpretive guidance to improve program oversight later this year. Areas that HRSA is expected to address include: the definition of patient eligibility, contract pharmacy arrangements and mechanisms to prevent ineligible patients from receiving the benefit and duplicate discounts for Medicaid patients.

Many AHA members, including critical access and urban safety-net hospitals, participate in the 340B program. For more than 20 years, Congress has provided relief from high prescription drug costs and enabled certain hospitals to stretch scarce federal resources to expand and improve access to comprehensive health care services for more patients, especially low-income and uninsured individuals.

Some stakeholders and interest groups, however, continue to spread misinformation about the program. Here are the facts:

- The 340B program accounts for only 2 percent – or \$6.5 billion – of the \$325 billion in annual drug purchases made in the United States.
- 340B hospitals provided \$28.6 billion in uncompensated care in 2013, which is four times the amount of drugs purchased through the 340B program. Participants reinvest the savings they receive on the discounted drugs in programs that enhance patient services and access to care. They also use these savings to provide free or reduced-priced prescription drugs to vulnerable patient populations.
- In 2013, one out of every three 340B hospitals had a negative operating margin.¹
- 340B hospitals are subject to oversight by HRSA’s Office of Pharmacy Affairs and must meet numerous program integrity requirements. These include yearly recertification, audits from HRSA and drug manufacturers and maintaining auditable inventories of all 340B and non-340B prescription drugs. In recent years, HRSA implemented additional program integrity efforts, and the AHA has encouraged HRSA to develop a process to help financially distressed providers meet the new program integrity provisions.

The AHA strongly supports the 340B program’s current intent and purpose. It has a proven track record of enabling eligible entities, including certain hospitals, to stretch scarce federal resources to expand and improve access to comprehensive health care services for low-income and uninsured patients. It creates savings on outpatient drug expenditures to reinvest in patient care and health activities to benefit communities and save government funds. Given the increasingly high cost of pharmaceuticals, the 340B program provides critical support to help hospitals’ efforts to serve the most disadvantaged in our society and build healthy communities.

RURAL PAYMENT ADJUSTMENTS

In its June 2012 report, the commission examined rural Medicare beneficiaries’ access to care, rural providers’ quality of care, special rural Medicare payments, and the adequacy of Medicare payments to rural providers. Much of the commission’s discussion focused on its assertion that not all rural hospitals are isolated. Specifically, the commission notes that 16 percent of critical access hospitals (CAHs) are located less than 15 miles from another hospital. However, there was no discussion of the full story of how these hospitals became CAHs, which is important contextual information.

Currently, to become a CAH, a hospital must be located either more than 35 miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads. However, prior to Jan. 1, 2006, this requirement was waived if a hospital was state-certified as a “necessary provider” of health care services to residents in the area. This

¹ American Hospital Association Annual Survey, data for 2013.

provision provided governors, who are much more knowledgeable about and in touch with the health care delivery systems in their states, the flexibility to waive the “one-size-fits-all” mileage requirement if they recognized that certain hospitals were absolutely essential to their communities.

We are concerned that MedPAC is using a one-size-fits-all consideration of these hospitals – viewing them only through the lens of proximity to the nearest hospital without any additional considerations. **In reality, there are many unique circumstances that must be taken into account when analyzing CAH location, including distance to the next nearest hospital, availability of post-acute care services, size of the hospitals, size and location of the surrounding population centers, weather, geography and posted speed limits.** Each rural community is unique and should be considered as such when discussing payment policy.

The commission also discussed the current low-volume adjustment and asserted that it is duplicative with the sole-community hospital (SCH) adjustment. **We strongly disagree with this conclusion.** The low-volume adjustment is obviously intended to account for the higher costs associated with treating a lower volume of patients – such providers frequently cannot achieve the economies of scale of their larger counterparts. The SCH adjustment, however, helps preserve access to care by targeting hospitals with higher-than-average costs given their circumstances. As MedPAC itself found in its June 2001 report, SCHs’ higher costs persisted after adjusting for certain factors, such as low volume, case mix and teaching activity. The commission stated that the higher costs could be due to other factors than scale, such as longer lengths of stay linked to an inability to place patients into appropriate post-acute care. Thus, the two adjustments address two different challenges faced by small, isolated hospitals.

CONCLUSION

The AHA and the hospital field appreciate your consideration of these issues. The AHA is committed to ensuring that the Medicare program continues to help the patients who depend on it. We look forward to working with the committee as it considers the important Medicare payment policy issues raised in the MedPAC report and at this hearing.

Hospital Timeframes to Rebill vs. Appealing Patient Status Denials

This timeline presumes implementation of the CMS RAC program changes announced in December 2014, as well as adherence by hospitals and contractors to statutory and contractual timeframes.

